1 Cameroon Country Report

NEEDS ASSESSMENT ON SAFE ABORTION ADVOCACY

FOR THE SOCIETY OF OBSTETRICIANS AND GYNAECOLOGISTS IN CAMEROON (SOGOC)

COMMISSIONED BY THE INTERNATIONAL FEDERATION OF GYNAECOLOGY AND OBSTETRICS (FIGO)
CONDUCTED BY: KIT ROYAL TROPICAL INSTITUTE – HEALTH UNIT

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4 Abbreviations

- DHS Demographic Health Survey
- D&C Dilatation and Curettage
- GDP Gross Domestic Product
- FIGO International Federation of Gynaecology and Obstetrics
- FP (PF) Family Planning
- HIV Human Immunodeficiency Virus
- MCH Maternal Child Health
- MMR Maternal Mortality Ratio
- MOH Ministry of Health
- NGO Non Governmental Organisation
- INS Institute National of Statistic
- KIT Royal Tropical Institute
- PPP Purchasing Power Parity
- RMNCAH Reproductive Maternal Neonatal Child and Adolescent Health
- SDG Sustainable Development Goals
- SOGOC Society of Gynaecologists and obstetricians of Cameroon
- SRHR Sexual and Reproductive Health and Rights
- UN United Nations
- UNICEF United Nations Children's Funds
- WB World Bank
- WHO World Health Organization

Executive Summary

This needs assessment set out to provide better and more in depth understanding of the capacity of SOGOC and in particular to identify the main abortion advocacy needs that a forthcoming multi country project can address. It also explored how FIGO can effectively strengthen the capacities of the society. The assessment involved conducting a literature review, a survey of members of the society, key informant interviews with stakeholders at various levels with the majority being associated with SOGOC as well as a stakeholder workshop for SOGOC members and partners.

The literature review, the key informant interviews and the workshop confirmed that unsafe abortion and its complications is a major problem in Cameroon, endangering the lives of many women. The practice of unsafe abortion is so rampant that the need for safe abortion to reduce this problem is urgent. The legal framework on safe abortion is limiting legal abortion to when it puts the health of the mother in grave danger and in case of rape or when severe foetal malformation are present that are incompatible with life. The penal code stipulates that a qualified person should conduct the abortion and a medical practitioner in case of rape. Safe abortions require signatures of three providers. The restricted access to safe abortion results in unsafe abortion practices. Advocacy for safe abortion faces many challenges where traditional norms as well as entrenched religious beliefs do not support safe abortion. To strengthen advocacy for safe abortion requires the engagement of various stakeholders and dialogue to win them over. SOGOC strong presence as a leader in technical knowledge has the opportunity to influence and network with like-minded organizations to advocate for and provide safe abortion services to women who require them.

Building its base as a safe abortion advocate, the association will require addressing the various and potential challenges as were identified during the key informant interviews and the two-day's workshop. This include the following:

- Strengthening the management and organization of SOGOC as a formidable agency for safe abortion advocacy.
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion.
- Transforming the social and gender norms at all levels regarding safe abortion but within the context of the Cameroon law.
- Shifting the law and penal code to better meet the needs of women.
- Ensuring a process for data generation and use for monitoring and planning for services.

These recommendations, identified in collaboration with SOGOC, were taken forward and translated into a preliminary action plan with tangible activities and outcomes. The action plan was further developed in collaboration with SOGOC and FIGO and formed the basis for the development of a program proposal for safe abortion advocacy in 10 countries (Kenya, Benin, Cameroon, Ivory Coast, Mali, Mozambique, Panama, Peru, Uganda, Zambia).

1 Introduction

This country report is the result of a need assessment conducted by KIT Royal Tropical Institute with the Society of Gynaecologists and Obstetricians in Cameroon (SOGOC) regarding Safe Abortion Advocacy. Cameroon is one of the ten countries participating in a broader Needs Assessment for an upcoming multi-country Federation of Gynaecologists and Obstetricians (FIGO)-led project that aims to increase the capacity of national obstetrics and gynaecology societies to become national leaders in safe abortion advocacy work.

1.1 Needs Assessment Purpose

This Needs Assessment is the first phase of an upcoming safe abortion project and should provide a better and more in depth understanding of the capacities and needs of SOGOC, to then identify the main needs in relation to safe abortion advocacy that the following multi country project could address. Also, it should provide more clarity on how FIGO can strengthen more effectively the capacities of national societies, in this case SOGOC. This includes the provision of recommendations on the content of the capacity building program by developing country action plans with budget, as well as a comprehensive program proposal for the whole ten countries.

1.2 Needs Assessment Objectives

The specific objectives are that by the end of the needs assessment in ten countries, FIGO should have:

- Insights on the situation of abortion in each country
- Understanding of the capacity and needs of each National Obstetrics and Gynaecology Society on abortion advocacy
- Plans of Action for each National Obstetrics and Gynaecology Society developed through a collaborative process
- Recommendations on FIGOs role to strengthen the capacity of the ten National Societies as abortion advocates, translated into a comprehensive proposal

2 Methodology

This Needs Assessment was formative of character and aimed for a highly participatory approach. This means constant mechanisms of communication and feedback with SOGOC took place in order to create mutual understanding and joint objectives.

The following methods were used in order to meet the objectives of the assessment:

2.1.1 Desk study review

A desk study review on existing literature and evidence was committed between February and March 2018 through a desk review tool. Academic databases and grey literature were searched for the relevant themes as addressed in the assessment framework (inception report). The literature review used existing literature using local university, United Nations (UN), Ministry of health (MOH) and Non Governmental Organisation (NGO) databases and reports to identify grey literature, SCOPUS, PUBMED and GOOGLE databases and WHO, World Bank and Guttmacher websites to identify relevant peer reviewed articles and background information.

SOGOC and key stakeholders were requested for relevant input.

2.1.2 Online survey

An online survey, using Survey Monkey software, was sent out to all 197 registered members of SOGOC to ask them about their membership of SOGOC, the position of the society towards safe abortion and their own professional and personal position towards safe abortion. On 14 February 2018 email invitations were sent out directly from the software. Despite a reminder on 15 March 2018, this resulted in a low response rate of 15. In total only 20 responses came back including 5 hard copies filled in during the workshop and entered manually in the computer in Amsterdam. Ten percent were not completed. The survey remained open for 7 weeks and closed on 3 April 2018. Analysis was done using the survey monkey software.

2.1.3 Key Informant Interviews

A total of 12 key informants were interviewed between 15 February – 03 March 2018. They included representatives from SOGOC, representatives of Community Based Organisations, (International) NGOs, and Association of Nurse/Midwives and from the Ministry of Health. The interviews were conducted within their offices. The selection of key informants included informants with various perspectives, some more in favour of full liberalisation of safe abortion, some in the middle and others who were not. We did not encounter informants with very strong, vocal opinions against safe abortion. With permission, the interviews were recorded as well as taking of notes. These notes were extended using the tape recordings. The notes were collated and organized along thematic areas as outlined in the findings section. The findings were analysed taking into account the various perceptions regarding safe abortion.

2.1.4 Stakeholder workshop

A two days stakeholder workshop took place in Yaoundé on 26-27 February. The purpose of the workshop was to identify the needs of SOGOC for abortion advocacy and develop a plan of action for the next safe abortion advocacy proposal that will be developed for the National Societies of Obstetrics and Gynaecology in ten countries involved in the needs assessment.

The objectives were that by the end of the workshops participants have:

- Discussed and identified opportunities and barriers for providing safe abortion in the country based on the desk review presentation and own experience.
- Explored their personal and professional values related to abortion and identified activities for improving access to safe abortion and post abortion care based on professional ethics.
- Explored the implications of the national abortion law and policies for access to safe abortion.
- The ability to explain the concept and levels of advocacy and identify challenges and barriers of abortion advocacy.
- Identified the strengths and weaknesses of the national society in abortion advocacy.
- Formulated action points for an abortion advocacy programme.

A total of 21 participants attended, most (19) being present for both of the days, some attending only the first or second day. A full program of the workshop and list of participants can be found in Annex 1.

2.2 Challenges and Limitations

One of the main challenges perceived was to get responses to the survey. In general, there seems to be a low tendency in responding to surveys and E-mail availability is still very limited in Cameroon. The team, in collaboration with SOGOC, took several actions to mitigate the limitation of a low response rate. SOGOC members that participated in the workshop and had not filled out the survey prior to attendance were requested to fill in the survey immediately upon arrival in hardcopy and several reminders were sent. With a total response rate of only 10% this survey cannot be seen as a reliable representation of the complete variety of SOGOC members. In addition, most respondents that filled in the survey were generally supportive of safe abortion to safe a woman's life and no persons entirely against abortion.

The challenges experienced in relation to the interviewing were largely the time limitation to cover all the relevant key informants. Despite several attempts, we were unable to interview the UNFPA person in charge of reproductive health issues. Despite these limitations similar issues kept emerging indicating a certain degree of saturation reached.

In terms of the workshop the attendance was largely by active members of the society. The attendants covered a variety of opinions and positions on safe abortion but none who were totally opposed to abortion.

3 Findings

3.1 Literature review

3.1.1 Social, economic, health population and demographic trends

Cameroon is an essentially young population, with more than half under the age of 20, while the under-15 age group is 40.5%[1], and 55 % lives in urban areas[2].

Despite being a low to middle income country inequities between the various regions is high with 56% of people living below the poverty line in rural areas and 8.9% in urban areas (GFF, 2018). Cameroon has a weak governance and health system with a relative high per capita expenditure for health it also has also a very high out of pocket expenditure of 70% of total health expenditure and 44 US$ per capita (WHO, 2018a). In addition, the density of health personnel is a 0,19 physician per 1000 population (World bank, 2010), unevenly distributed (MOH, 2012).

Access to services is problematic in Cameroon especially in the rural areas. The weak health system and unequal distribution of health services is illustrated by the relatively high under-five mortality rate of 251/1000 in the extreme North and 112/1000 in the centre areas of Cameroon (Tandi et al, 2015).

3.1.2 Maternal health, setting the stage at global level

Improving maternal health and reducing maternal mortality remains at the centre of global health initiatives. The majority of countries in Sub-Saharan Africa did not meet the Millennium Development Goal 5 whose target was to reduce maternal mortality by 75% (of the 1990 maternal mortality ratio) by 2015. More than 80% of an estimated 289,000 annual maternal deaths are due to obstetric haemorrhage, obstructed labour, hypertensive disorders (e.g., severe preeclampsia or eclampsia), complications related to abortion, and postpartum sepsis (WHO, 2014).

In an effort to accelerate the achievement to Millennium Development Goal (MDG) 4 and MDG 5, the UN Secretary-General launched the Global Strategy for Women's and Children's Health and a high-level Commission on Information and Accountability (COIA) set up to promote global reporting, oversight, and accountability on women's and children's health[3] Building on these efforts, the Sustainable Development Goals (SDGs) have been set up to establish a transformative agenda for ending preventable maternal deaths. Target 3.1 of SDG 3 is to reduce the global MMR to less than 70 per 100 000 live births by 2030[4]. Achieving this significant reduction will require an average of 7.5% reduction of global MMR annually between 2016 and 2030; more than three times the 2.3% annual rate of reduction observed globally between 1990 and 2015.

3.1.3 Key indicators Cameroon

Whilst globally the maternal mortality rate decreased with 43% between 1990 and 2015, maternal mortality has been slow to decrease in Cameroon showing a decrease of about 200 between 1990-2015 with a high standard deviation [from 782/100.000 (S.D. 566-926) to 596 /100.000 live births,

[1] http://countrymeters.info/en/Cameroon#population_2018

[2] https://www.indexmundi.com/facts/cameroon/indicator/SP.URB.TOTL.IN.ZS

[2] https://www.indexmundi.com/facts/cameroon/indicator/SP.URB.TOTL.IN.ZS

[3] http://www.who.int/life-course/about/coia/coia-and-ierg/en/

[4] http://www.undp.org/content/undp/en/home/sustainable-development-goals/goal-3-good-health-and-well-being/targets.html

(S.D. 440-881)] (WHO, 2015). According to Leke (2018), the major direct obstetrical causes of maternal death include haemorrhage (24%), complications of abortions (30%), infections (15%), preeclampsia/ eclampsia (12%) and obstructed labour (18%) (Leke, 2018).

Table 1: Demographic and socio economic indicators for Cameroon

Demographic and socio economic information	**Vital Statistics**
• Pop 2016: 22.70 million • Nominal devolution/ decentralisation but with financial bottlenecks. (APA newsnet, 2017) • GDP per capita 1032 USD (WB, 2016) Annual GDP growth rate 4.10 (WB, 2016) • Below poverty line in 2014 38%; range rural 56-8.9 urban (WB, 2016) • No national Health Insurance • General public health density 1.97 to 0.50 / 1000 population in the centre and the North (MOH, 2012) • Per capita Health Expenditure Current US$ 64 in 2015 (WHO, 2018a) • Out of pocket expenditure in current US$ 44 in 2015 (WHO, 2018a).	• Life Expectancy total: 57.3 years (WHO, 2015) • HIV prevalence 4.3 (DHS 2011) • IMR: $60/_{1000\ \text{live births}}$ (MICS, 2014) • MMR: 596 (440-881)/$_{100.000\ \text{live births}}$ (WHO, 2015) • Delivery with skilled attendants- 64.7% (MICS, 2014) • mCPR 21% among married women(MICS 2014) • Unmet need for family planning among married women 33.8 % (FP2020, 2017); 18%, (MICS, 2014) • Early pregnancy: 27.5% (2014, MICS) • Adolescent birth rate 119/1000 (2014, MICS)

Globally unintended pregnancies are estimated to be 89/1000 among women aged 15-44 in developing regions and 65/1000 in developed regions. The incidence of unintended pregnancies is 38.6% of the total pregnancies in Cameroon. A high estimated unmet need for family planning of 33.8% (FP2020; 18%, MICS, 2014) and a very low modern contraceptive use, 21% (MICS, 2014) contributes to a high level of unintended pregnancies. The latest DHS data show that the proportion of Cameroon women (15-49 years) using a contraceptive has slightly increased from 12% (DHS, 2004) to 14% (DHS, 2011) and from 14% to 16% for women aged 20-39 years (EDS 2011: 10-13, preliminary report). Use of modern contraceptives is highest in Douala and the South-West (21-22%) and lowest in the North and far North (below 5%) (Draft summary DHS, 2011) Barriers to the use of modern contraception include myths surrounding their use, availability, taboos, religion, opposition from husbands, health reasons, and fear of secondary effects, culture and ignorance (Leke, 1998; Schuster, 2005). 90% of the women interviewed in the DHS of 2004 knew at least one modern method of contraception.

In general, characteristics of women (and adolescents engaged in early sexuality and marriage) with unintended pregnancies are poverty, low levels of education, low socio-economic status, living in poor neighbourhoods both in urban and rural settings (Guillaume, 2005; MICS 2014:125-126). Use of modern contraceptive methods is very low among adolescents, one of the most vulnerable groups in Cameroon, both in and out of school. Lack of youth friendly services limit the access to contraceptives for adolescents. Several studies show that between 21 and 41% of unmarried adolescent girls state that they are sexually active. A study conducted among girls in an urban secondary school showed that 21.3% of girls admitted being sexually active and out of these 64% were between 10-16 years at their first sexual contact (Foumane, 2013). Leke (1998) found that 41%

of adolescents in school were sexually active. Among Cameroonian women aged 15-49 years, 25 % had sexual intercourse before their 15th birthday (NIS/DHS, 2004). In the same DHS it was found that the age at which women get into unions (traditional and or legal marriages, co-habitation) is at least 1.3 years later than their first sexual intercourse (DHS, 2004) Internally displaced populations and refugees from Congo, Central African Republic and Chad, persons migrating to the bigger cities and HIV Positive women are also vulnerable to unintended pregnancies (UNICEF, 2014, Medicines Sans Frontières, 2018).

Abortion incidence and prevalence

The 2017 report on abortion worldwide by the Guttmacher Institute shows that 56% of unintended pregnancies are estimated to end in abortions. The global incidence of abortions is estimated at 35/1000 women aged 15-44 and 36/1000 in Africa. Little variation in the number of abortions was found between countries with varied economic or between countries with legal restrictions (37/1000) and without legal restrictions (34/1000). (Guttmacher, 2018).

Significant differences are found in the percentage of unsafe abortions related to the legal conditions in countries. The percentage of unsafe abortions increases when abortions laws are more restrictive from 1% in least restrictive settings to 31% in most restrictive settings (Guttmacher, 2018). As a result of the restrictive nature of the Penal Code law on abortion in Cameroon and other contributing factors, the majority of abortions are carried out illegally and in poor hygienic conditions (Shaw and Ahman, 2012; Adetoro O, 1986, Anne Emmanuelle C, 2002).

In Cameroon, abortion is defined as the expulsion of the product of conception before the 28th week of pregnancy and may be spontaneous or induced or therapeutic (Leke, 2018). The real incidence of induced abortions is difficult to estimate in Cameroon due to the limited legal access to abortions and data available is mostly based on cross sectional studies in selected hospitals. A recent study (Ngowa, 2015) conducted in 2 urban and 1 rural hospital among all women who were seeking gynaecology and obstetric services, during a period of 3 months in 2011, showed a prevalence of 25.6% induced abortions in the urban and 27.1% in the rural hospital. Most (83%) cases of induced abortions were carried out in a health facility and 23 (17%) cases in private homes. Cameroon is following the WHO definition for safe abortion that regards an abortion safe when provided by a qualified provider in a suitable equipped environment. Medical doctors and other health providers who are trained in conducting MVA and medical abortions before a gestation of 8 weeks can provide safe abortions. However, private homes and health facilities are not always well-equipped making abortions unsafe and/or providers are not qualified. Medical doctors and nurses were the most frequent abortion providers in both urban (84.7%) as well as rural setting (77.2%)(Ngowa, 2015).

There is no national level mechanism for monitoring and evaluation of maternal mortality and morbidity resulting from unsafe abortions. The complications of abortion, especially of unsafe abortion, can be severe, for example:

- ✓ Haemorrhage sometimes leading to shock and death of the mother;
- ✓ Intestinal perforations as a consequence of unskilled practice;
- ✓ Perforation of the uterus and bladder as results of unskilled abortion providers (WHO, 2005).

In a report on the situational analysis of abortions in Cameroon, the FIGO working group on unsafe abortion noted, “unsafe abortion is a common problem in Cameroon where it is responsible for 30% of emergency admissions and about 32% of maternal deaths” (Florence Tumasang et al, not dated)

In the same line, the estimates from the maternity of Yaoundé Central Hospital (one of the main referral hospitals in Cameroon) and 2 other referral hospitals, abortions accounted for 24.2% to maternal deaths (Tiako Kamga et al., 2017: 4). Around 30% of maternal deaths are caused by complications of unsafe abortions (Leke, 2018), and over 85% of infertility cases are a consequence of abortions (Leke: cited by Mounah Dipita, 2001).

In the Ngowa study complications were reported by 20% (27/134) of respondents who had carried out voluntary induced abortion. Excessive bleeding was the most reported complication (70.4%) (Ngowa et al, 2015).

Characteristics of women seeking abortion

A common finding is that the age group of 20 to 29 years was most represented in various studies (Tiako Kamga et al., 2017: 4, Ngowa, 2015, Leke, 2005).

Both married and unmarried women as well as rural and urban women seek abortion services. It should be noted that women in Yaoundé / Douala (14%), in secondary school or above (10%) and those in the richest households (14%) most frequently reported using induced abortions (NIS, 2011). The Ngowa study showed that more than half of the study population were students or unemployed women, and a majority (89%) of the women had had at least primary education and 21% secondary education (Ngowa, 2015)

3.1.4 Legal and policy context

As in most African countries, the Cameroon Penal Code related to abortion is still very restrictive. In article 339, the Penal code stipulates exceptions in which abortions can be done within the extent of the law, being (1) If the health of the mother is in grave danger; (2) Pregnancy resulting from rape after evidence has been established and (3) Eventually in case of very severe foetal malformation incompatible with life. The qualified person can be a trained midwife in Cameroon but needs an additional signature from one medical doctor. In case of rape the attending physician must consult a legal medical expert and the prosecution must present a 'good case'.

The law on abortion in Cameroon has, in effect, two official versions of its Penal Code, one in French and one in English. Although the major provisions of the two versions are identical, they differ in certain details. Under the Penal Code (sections 337-339), the performance of abortions is illegal except if proven necessary to save the mother from grave danger to her health or when the pregnancy is the result of rape. According to the French version of the Code a qualified person must perform the abortion. The English version stipulates that in the case of a threat to health the abortion must be performed by a qualified person, and in the case of rape by a qualified medical practitioner. In the case of rape, the French version provides that the public prosecutor's office must certify the materiality of the facts, and the English version, that the prosecution must certify a "good case." Anyone performing an illegal abortion is subject to one to five years' imprisonment and a fine of 100,000 to 2 million CFA (1500-3000 euro). A woman who procures or consents to her own abortion is subject to imprisonment for fifteen days to one year and/or a fine of 5,000 to 200,000 CFA. Penalties applied to medical professionals who perform illegal abortions shall be doubled and they may be prohibited from carrying out their obligations or be subject to having their professional premises closed (Republic of Cameroon, 2016).

In summary: Safe and legal abortions must be performed by a qualified person. In the case of rape, the prosecution or the public prosecutor's office must certify in English a "good case" or in french

the materiality of the facts (forensic or otherwise presented facts) before the abortion can lawfully be performed. Moreover, some key points need to be highlighted:

- Therapeutic abortions are allowed in Cameroon legally to save the woman's health from grave danger.
- Abortions are not allowed to preserve women's mental health.
- The law allows for abortion of pregnancies resulting from rape and incest and is permitted when severe malformations are not compatible with life.
- Abortions are not legal for socioeconomic reasons or women's choice.
- Abortion is illegal except in cases where the health of the woman is in grave danger. Other exceptions include rape and severe foetal malformations that are incompatible with life (UN, 2008)

In reality, women are rarely prosecuted or imprisoned because of induced abortions. Heath personnel are not required to report the cases. Health personnel generally follow the ethical principle of confidentiality of health records in the care of women with induced abortions. Physicians and other health professionals are rarely prosecuted but some have gone to prison in cases that ended up in maternal mortality (Schuster, 2010, interviews and stakeholder workshop).

3.1.5 Service delivery environment

The comprehensive abortion services range from prevention to the provision of safe abortions and post abortion care. In terms of prevention, four types are implemented by SOGOC. They include (1) Primary Prevention: Prevent all unwanted pregnancies; (2) Secondary Prevention: Ensure safe and secure abortion in conformity with the laws of the country; (3) Tertiary Prevention: to prevent complications from D&C and improve the quality of post abortion care with MVA or Misoprostal; (4) Quaternary Prevention: Ensure adequate counselling and post abortion contraception which should be administered before discharge (SOGOC members information).

In Cameroon the service providers such as nursing aids that do deliveries at community level are trained to do deliveries but are not certified midwives, health education about FP, abortion and post abortion care is provided at this level by nursing aids and NGOs. Medical doctors and nurse/midwives are trained to provide antenatal care and deliveries and provide PAC, medical abortion and MVA up to 8-12 weeks, the hospitals are equipped to address complications of abortion and provide therapeutic abortions between 8 and 28 weeks. Since some years nurses and midwives are trained on comprehensive post abortion care including MVA and Long Acting Reversible Methods (Tumasang et al, 2014). The health pyramid in Cameroon begins with level 1 (general hospitals), to level 2 (central hospitals), level 3 or regional hospitals, level 4 or district hospitals, level 5 or sub-divisional hospitals, level 6 or integrated health centres.

Qualified providers for the provision of safe abortion are: trained nurse midwives and medical doctors. Misoprostol is available, registered and used for induction of labour. This medication is also available in both public and private pharmacies in Cameroon. Among women visiting the gynaecology and obstetrics wards with PAC complications, abortion services were conducted in health facilities (83%), that is 43% in public and 40% in private health facilities), and 17% in private homes. The majority of abortion providers were medical doctors (35%) and nurses (33.7%). Gynaecologists/obstetricians provided abortion in 13% of cases in the rural hospital and 20% in the

urban settings (Ngowa, 2015). Referral is a problem due to lack of transport and infrastructure. Therefore, providers in the periphery need to be trained more (SOGOC member interview).

3.1.6 Quality of care

The methods used for care of women with incomplete abortions include dilatation and curettage (D&C), uterine evacuation, digital exploration and manual vacuum aspiration. D&C was the preferred methods until SOGOC, as part of the FIGO prevention of unsafe abortion project, started in 2012-2013 introducing MVA as a preferred method for post abortion care. MVA was then rolled out as a preferred method countrywide (Tumasang et al, 2014). The government of Cameroon instituted emergency obstetrics and neonatal care in 2005. The components of this high impact practice contained post abortion care (PAC) that includes the use of MVA. High Impact Practices were introduced in all the ten regions. SOGOC members were used and are still being used to roll out emergency obstetric care and the use of MVA but it was government policy to introduce and institutionalise the use of MVA. The follow up and monitoring of quality is very important to ensure quality of care (interview SOGOC member). The use of MVA is available in most of the district hospitals and health centres and city and town hospitals (public and private) as well as in university teaching hospitals. Access to post abortion care (PAC) is mostly limited by financial means. There is also stigmatization when young women or girls come for PAC (Florence Tumasang et al, not dated).

There are no national guidelines for the provision and training for safe abortion, yet. These are being developed (Interview SOGOC member). Physicians and other health personnel are trained according to the different curricula of their medical schools in relation to National norms and not the WHO recommended methods. For example, only recently MVA was integrated in the training of medical officers, nurses and midwives pre-service training *et a,l* Tumesang, 2014). Cameroon SOGOC members recognize that they implement the WHO recommended list of essential medicines that includes mifepristone/misoprostol and essential commodities list of WHO and UNFPA that includes MVA. Implementation of the use of MVAs is dependent on the availability of equipment distributed to health facilities. The distribution of MVA kits is not always sufficient resulting in shortages of equipment Florence Tumasang *et al*, not dated; interviews).

3.1.7 Costs of abortion

Besides the costs of obtaining an abortion, the costs of unsafe abortions are multiplied when post abortion complications arise. From various interviews with SOGOC members it emerged that the costs of PAC due to unsafe abortion vary depending on the health sector and the hierarchical level solicited by clients. The prices may be low as 7000 CFA (about 10 euro) in some health centres to as high as 476,000 CFA (about 700 euro) in some private institutions. For instance, in the MP-HCY, it ranges from 19 000 to 25 000 CFA (25-38 euro) whereas in the private informal health centres, it ranges from 31 000 CFA to 70 000 CFA (47-106 euro) and above (Leke *et al*, 2007).

3.1.8 Practices of unsafe and illegal abortion

Health providers that are not qualified, such as paramedical professionals and medical students not trained and authorised conduct unsafe abortions, or unsafe abortions are conducted in a not suitable environment. Other providers of unsafe abortion include: pregnant women themselves, traditional practitioners, and pharmaceutical assistants. Dangerous methods are used for inducing abortion causing serious health complications. People make use of various methods including:

Household products orally such as honey, salt, whiskey, tobacco; Illicit pharmaceuticals such as nivaquine, quinine, aspirin, intra-vaginal permanganate tablet and various injections that can cause abortion; Intra-uterine insertions such as lemon + hot water + pepper, bicarbonate, laundry blue + snail; Application of punches on the lower abdomen by a third party (girlfriend, boyfriend, comrade), among others (Ngwe & al, 2005 echoed by Bibang-bi-Essono (2010: 34).

3.1.9 Stigma and reasons for unsafe abortion

Women resort to unsafe abortions like the practices described above in consideration of costs and privacy (Ngowa, 2015). Privacy being of utmost importance because of the illegality of abortion in general and the stigma attached to abortion. Reasons given for unsafe abortion by women during hospital studies among women who had an induced abortion were, especially for young people, to pursue their studies (34.3%), not married (22.6%) and fear of parental disapproval (13.9%) (Ngowa, 2015; Schuster, 2005). Qualitative interviews showed that an induced abortion was often sought with the support of girlfriends and mothers (Schuster, 2005). Other reasons were economic considerations and contraceptive failures and pregnancies too close together, which may endanger a woman's life (Ngowa, 2015; Schuster 2005; Bibang-bi-Essono, 2010: 25).

Stigma was more related to the association with possible complications, resulting in infertility and to some extend the notion that many women would like to carry a child, and much less on religious grounds. Abortion is condemned in public but often accepted as a necessary evil on these grounds The fear for public knowledge of an abortion was much greater than the fear of police or prosecution and informed the need for privacy and secrecy often resulting in late presentations of complications (Schuster, 2005).

3.1.10 Advocacy and measures to prevent unsafe abortions

Measures to prevent unintended pregnancies include comprehensive sex education, contraceptive information and services, including availability for youth friendly services and access to contraceptives for unmarried adolescents (Chandra-Mouli, 2017) and raising parents' awareness of more dialogue with their children about their sex lives; public awareness of the harmful effects of abortions; training and capacity-building for health staff on abortion care and post-abortion care; the increase in contraceptive use among women (Belley Priso *et al,* 2010). To reduce the number of clandestine procedures, legal grounds for abortion need to be expanded in the region and access to medical services needs to be improved, service delivery guidelines need to be written and disseminated, providers must be trained and governments must commit to ensure access to safe medical practices under the auspices of the law (Guttmacher, 2015). The Bishops of Cameroon on the subject of abortion stresses the continuous formation of youth is the way of salvation. Families need to organize and consistently provide abortion prevention through training and information for youth, families and all of society.

The major challenge for the MOH in Cameroon is to set up suitable services for married and unmarried adolescents that attend to difficult subjects, such as sexuality. Community leaders, and religious leaders, need to learn about the risks of early marriages and consequences of early childbirth. Some of the suggested immediate policy implications are that a national program on sex education should be set up with the aim of encouraging the use of peer groups and media (including social media) to broadcast messages about safe sex before and after marriage (Fonjong, 2017).

Various organisations in Cameroon, such as women for change, IPPF, PSI, RENATA are advocating for safe abortion services, changing the legality conditions and provision of contraceptives.

3.2 Online survey

3.2.1 Response rate

The response rate of the online survey was very low. Twenty surveys were handed in providing a response rate of 10% only. Various questions were not completed answered resulting in a completion rate of 90%. Therefore, the results cannot be generalised for the society in Cameroon. The results are looked at as additional information to the interviews and the outcomes of the workshop, providing some background to the variety in perceptions.

3.2.2 Characteristics of the respondents

The majority of the gynaecologists who filled in the survey were very experienced. Most had between 5-15 years experience (9 respondents, 45%) and between 15 and 30 years (8, 40%).

It is likely that the low response rate has led to a biased sample showing that most involved and active members took part in the workshop and filled in the survey:

The respondents that filled in the survey were generally very involved (6 respondents, 32%) or involved (5, 26%) or moderately involved (5, 26%).

Out of the 19 society members that filled in the survey 15 (79%), attended always or often to the activities such as meetings, trainings, conferences and special thematic events.

3.2.3 Communication between SOGOC and its members

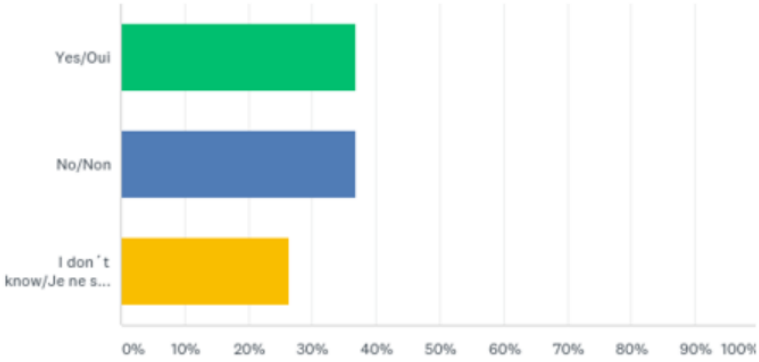
The most frequent mode of communication in the society is still per post (18 respondents, 95%), by WhatsApp (9, 47%) and calls (8, 42%). The Internet is not so much used with only five respondents recalling to have received communication by email. Most communication takes place at a quarterly basis. A vast majority of respondents found that the communication should be strengthened: Respondents perceived the communication as acceptable but could be strengthened (10, 53%) or poor and needed strengthening (8, 42%).

3.2.4 About SOGOC's position towards safe abortion

Communication on the SOGOC policy on safe abortion is problematic. A minority (7, 37%) stated that the policy clear and only four thought that the society informs its members about its position on safe abortion. Of the seven respondents who did know the society's position towards safe abortion two (29%) strongly agreed, four (57%) agreed with the policy that the society follows the constitution of the country and one was neutral. Thirteen members did not know the society's position or did not find it clear.

Q12: Does SOGOC have a clear position towards safe abortion?/Est-ce que la SOGOC a une position claire envers l'avortement sécurise ?

Answered: 19 Skipped: 1

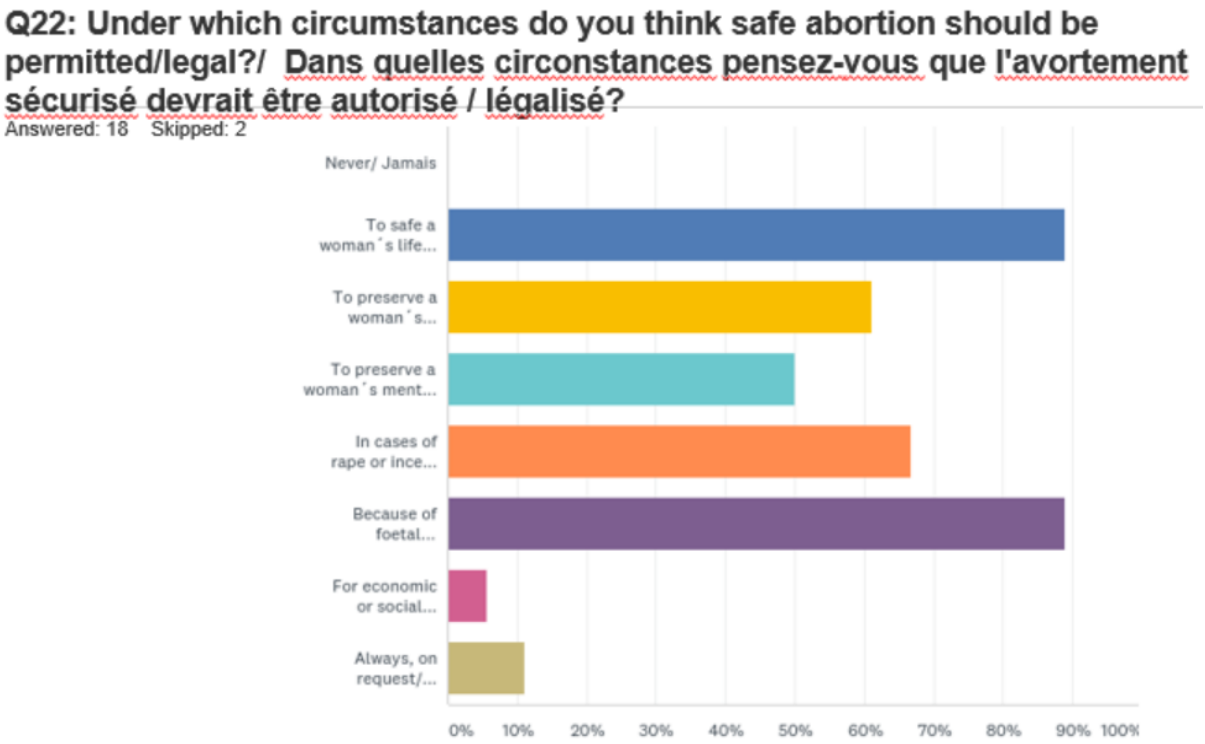


Most (11 out of 19, 75%) respondents did state that the society informs its members about abortion laws, policies and practices. The means of communication is mostly during meetings (11, 61%) and trainings (8, 44%), and less through Internet (5, 28%) or other means (5). Eighteen respondents out of (100%) would like to receive more information about themes related to safe abortion.

3.2.5 Respondents position on safe abortion

Around half of the respondents felt informed to well informed about national laws, policies and guideless, recommendations and procedures on safe abortion (9 out of 18, 50%) and more than half felt informed or well informed about international laws on safe abortion. Over half felt informed or well informed about policies (13, 72%) and guidelines (11, 61%) on PAC. Least informed (5, 27%) felt respondents about national laws on safe abortion. However, 22% (4) to 39% (7) felt not to only slightly informed about these themes.

A vast majority feels that abortion should be permitted to safe a woman's life and because of fetal impairment, and more than half to preserve a woman's physical health and in cases of rape or incest. Half of the respondents find that abortion should be permitted to preserve a woman's mental health and a small minority feels that abortion should be permitted for social or economic reasons (1) or always, on request (2). No respondent feels that abortion should never be permitted.



More than half of the respondents agree with the following statements:

- Health workers opposing to perform safe abortion should be obliged to refer women to other health workers that will perform a safe abortion (22% (4) agree, 39% (7) strongly agree)
- Health workers have role to play as advocates for safe abortion (28% agree (5), 33% (6) strongly agree)
- Post abortion care is part of healthcare and should not be separated from the rest of health care (11% (2) agree, 50% (9) strongly agree)
- Health workers should be obliged to provide post-abortion care to all women, no matter if the abortion was legal or not (17% (3) agree, 44% (8) strongly agree).

And disagrees with:

- Safe abortions should be only performed in private clinics, not in the public health system, (11% (2) disagree, 33% (6) strongly disagree)
- Health workers should report to the respective authorities cases with signs of illegal abortion (17% (3) disagree and 44% (8) strongly disagree)

On the following statements a variety of opinions emerged with a large neutral component (44-39%). A significant majority for either agreement or disagreement was not found:

- Safe abortion is part of healthcare and should not be separated from the rest of medicine.
- Specialized health workers (Obs-Gyn) should be obliged to perform safe abortions in cases where it is permitted by law
- Health workers should have the right to decide whether to perform or not safe abortions according to their personal values and positioning towards abortion

Just more than half (56%, 10) of the respondents say to support SOGOC in advocacy for safe abortion and 22%, (4) possibly. A small minority would probably (2) or definitely not (1) support such advocacy activities.

3.2.6 Summary

It is likely that the low response rate has led to a biased sample showing that most involved and active members took part in the workshop and filled in the survey. The most common means of communication is still per mail followed by phone and WhatsApp.

Communication on the SOGOC policy on safe abortion is problematic with very few respondents knowing the position. The respondents knowing the position are most likely the ones most involved in the work of the society around safe abortion and of those seven only two strongly agree with the policy. Sharing of information about safe abortion evidence, policy and practices is well received. The most common route of communication about evidence, policy and practices is through meetings and trainings. Half of the respondents felt informed about international laws, policies and guidelines for safe abortion, and more than half about PAC. Respondents felt least informed about national laws on safe abortion. Almost all would like to receive more information about themes related to safe abortion.

A majority would like to see the legal situation should be changed to permit abortion because of foetal impairment and a woman's physical health. Half thought preserving a woman's mental health should be a reason for a legal abortion and only a few found abortion to be permitted in case of economic reasons or at a woman's request.

The respondents show just over half to agree with the obligation of health workers to refer a woman for safe abortion, perform an abortion irrespective of the legality of the situation and to support advocacy for safe abortion. There is hesitation to agree or disagree with on, one hand obliging health workers to perform a safe legal abortion and permitting personal beliefs and values to determine medical practices.

3.2.7 Conclusion

The following elements of the society are indicated for improvement: communication between members taking into account the need of sending information by mail. Use of social media seems a promising option for improved communication. There is a need to clarify the society's position on safe abortion, increase the commitment to advocacy for safe abortion and address the role of the society in meeting women's needs for safe and legal abortion. The implication is that work on advocacy needs to happen within the society and partnership with NGO's may, at least initially assist in this.

3.3

3.4 Key Informant Interviews (KII)

Table 2: Key Informant Interview participants

No.	Association/ Society/Organisation	No of Respondents
1	SOGOC	5
2	CAMNAFAW (IPPF)	2
3	RENATA (local NGO)	1
4	ACMS (PSI)	2
5	ARGOC (resident gynaecologists/obstetricians	1
6	ASFAC (Association of nurses and midwives)	1
7	Ministry of Health	2
	TOTAL	**14**

Data collected from the key informant interviews were analysed based on the following broad thematic areas:

- Safe abortion environment
- Professional associations' position on safe abortion
- Level of influence on policy change
- Relationship between professional societies
- Personal position on safe abortion
- Obstacles to safe abortion advocacy
- Opportunities for strengthening safe abortion network
- Current role in safe abortion advocacy.

3.4.1 PRIMARY DATA ANALYSIS OF THE SITUATION AT THE NATIONAL SOCIETY

3.4.2 Safe abortion environment

In the Cameroonian environment, all respondents find that abortion is a real public health problem. According to the informants interviewed, abortion is responsible for hospitalization and death of women of childbearing age. As a result, the issue of abortions needs to be addressed comprehensively by integrating all key sectors of the social and cultural environment. One SOGOC informant points out that:

> *"Yes, as a practitioner anyway, we meet so many cases in the hospital every day, sometimes in deplorable situations that lead to the deaths of girls and young women …. and I think that is a problem for us, it is a problem that is serious that is to say it must be addressed in all the different aspects of problem…." (Interview – SOGOC member).*

The legal framework, Cameroon law (Penal Code) prohibits abortion practices. This legal barrier seems to open the way to clandestine unsafe practices. The following quotes of community-based associations illustrates this:

> *"(….) what we do know is that despite this (restrictions by law), people do it (abortion) a bit illegal. As a result, those who do not have access (…) are trying a thousand and one things to have an abortion, which often leads to sometimes fatal complications." (Interview local NGO)*

"[...] although there is a barrier in that the law does not allow abortion, [...] it is still done [….] we meet mostly with adolescent mothers ". (Interview –local NGO).

3.4.3 Professional association 'position on safe abortion

Members of professional associations have more or less divergent positions on abortion laws in Cameroon. Some advocate for relaxed procedures, others take a radical position on legislation. Still others are in the middle between banning and opening access to abortion. Those who are in favour for relaxation of the proceedings argue that the decision for a woman to have an abortion is often irreversible and the legal prohibition of the practice pushes them to take more risk by going to have an abortion by unconventional means. On the other hand, they mention the complicated nature of the procedures even for the cases of authorized abortions:

"I think the majority of ARGOC (association of resident gynaecologists and obstetricians in Cameroon) members agree that more access is needed, that the legal barriers are too restrictive, that women have to get more autonomy to decide, about their life and their health, so they are for the most part pro choice, for the choice of the woman". (Interview ARGOC member).

For those who remain dubious, they nevertheless advance arguments for and arguments against each side. On the one hand, they point out that completely liberalizing abortions would encourage the proliferation of providers who already do so in non-compliance. On the other hand, legalization may lead to a rush on the phenomenon.

"The official position of the association is that we do not have the evidence that by legalizing will solve the problem. […] we are afraid that by legalizing, those who have decided to give birth in homes will now decide to do the abortions. But not because we think it's a bad thing "[...] if we asked society today to decide for or against, you'd have a proportion of people for, you would have a proportion of people against, but in the middle we all meet "(Interview – SOGOC member).

3.4.4 Level of influence on policy change

To hope for a change in unsafe abortion attitudes and practices, informants suggest using well-organized lobby as well as opinion leaders and other political and parliamentary forces. In this respect, a MoH staff argued:

"If we want to do something it is really lobbying we need. We must, because even public opinion, politicians who say they are against abortion, most often they are based on their conviction, so religious to be able to have this opinion ". – interview MOH

In the same perspective, a member of ARGOC makes concrete proposals for implementing strategies to influence decision-makers:

"Cameroon has failed to bring down its maternal mortality .. and we have evidence that the unsafe abortions remain one of the leading causes of maternal mortality. Thus at the level of law-makers, be it senate or parliament, it must be said that as long as Cameroonian women will not have access to quality reproductive services including safe abortions, these figures will never go down, so it's time to do something. At the level of the government, whether it is

the MINSANTE which is the mother ministry, whether it is the ministry of the woman of the family, of social affairs, we must put in place policies, which give access to safe abortion to women who are the most underprivileged members of the community in the Cameroonian and African context".

In addition, an informant from an international NGO has this to say:

"We need to engage the traditional leaders in these talks because it is necessary to bring this information back to their community as well. Engaging religious leaders would be the hardest thing for me, but maybe if we are the victims (women) can in real time, talk to these religious leaders about their experience, their experiences, how much they have been martyred …..

3.4.5 Relationship between professional societies

There is an interrelationship between professional societies and other relevant organizations. Partnership agreements bind institutions together. SOGOC and the Ministry of Health are often referred to as preferred partners for training, exchange of experiences and referral.

"[…] we have several partnership agreements with the Ministry of Health. Also with SOGOC, we have had a strong partnership for several years. They are responsible for all the training in RH. They intervene in the accomplishment of some of our studies. [...] we are regularly invited into their workshops so that we can make our modest contribution to thinking about RH in general and about abortion in particular."(Interview-international NGO)

Also without a formal MOU relationships exist through workshops and other activities:

" we do not have a direct collaboration structure, but I can say that we have good relations, we met often at workshops, exchanged and shared experiences from where he (SOGOC) has responded to gaps in needs or supplement the information I needed… we think of having a direct collaboration, a partnership to refer cases …."(Interview local NGO)

For others, collaboration is part of an official arrangement. For example, the midwifery and nurses associations are members of SOGOC.

SOGOC has a framework agreement with the MOH and seems to be called on at one time or another for advice and decision making.

"We have a framework agreement with the Ministry of Health, which would normally be for decision making that we are being called. [...]even when they started certain things without us, at one point they realize that we still have to give our opinion." (Interview SOGOC member)

Together with other partners, including civil society and NGOs, SOGOC collaborates with all organizations that integrate community-based activities into their maternal and child health guidelines.

"We have partners with whom we have good relations, for example, the society of, midwives and the paediatricians at least all those who intervene in the framework of

the health of the mother and the child including civil society [….] We have framework agreements with two NGOs that do community activities including NOLFOWOP and OFSADE. Other institutional partners are […] UNFPA, UNICEF, and GIZ, they call on SOGOG when they need the expertise of SOGOG….” (Interview – SOGOG member)

3.4.6 Personal position on safe abortion

Personal positions of respondents are generally for liberalization but with certain reservations. Some advocate for legalization but insist on the need for supervision and review of conditions of authorization. This is what this informant points out.

“No. I personally do not support total legalization. I think we have to relax a few threads here and there, but all this must be done in a well-supervised context. We really need to be able to define who we will really give access to abortion care and under what condition. [...] "(Interview- ARGOC)

Others accept legalization but insisted that strong advocacy should be carried out for the prevention of unwanted pregnancy and unsaved abortion. Without moving away from the prevention-based approach, others adhere in part to the official position of prohibition. This is what emerges from these remarks:

"[...] I promote prevention, that is, family planning, post abortion care, and then stay within the legal framework [...] I think of a clinical point of view, human ethics, professional conscience, I do not align myself one hundred percent for this position. But I wish that one day the legal environment of my country could allow young girls to stop doing unsafe abortions at all." (Interview key informant - MoH).

An ARGOC member added:

"There are legal barriers with doctors who are very eager to provide these services but are afraid of reprisals in terms of prosecution because they say that according to our legal provisions for the moment they will not be covered if clients or family members complain. (Interview conducted on ARGOC member)

From the interviews it emerges that all respondents call for information and sex or health education for the prevention of unintended pregnancies to reduce unsafe abortion. The interpretation of sex education for youth differs. For some respondents it means implementation of comprehensive sex education and youth friendly services providing contraceptives for adolescents. For others it means a call for abstinence among unmarried youth as the only option and there is a lack of awareness or acceptance about the in-effectiveness of this strategy for the prevention of unintended pregnancies and unsafe abortions.

3.4.7 Obstacles to safe abortion advocacy for legalisation of safe abortion

The problem of the legalization of abortion in Cameroon encounters several obstacles. Advocacy for the promotion of safe abortions carried out by community-based organizations and some other actors face several obstacles. These barriers may be related to abortion legislation, political consequences, unavailability of means of implementation, lack of

awareness of the law, personal beliefs and lack of audience. As a result some respondents do not advocate for full liberalization but to relax existing conditions.

> *“I see as barriers to advocacy: personal beliefs, ignorance of the law, lack of knowledge about abortion as a contribution to MMR. We need more public awareness and reach politicians.” (Interview SOGOC member).*

> *"First we talk about the legal restrictions and we also have religious and traditional barriers (…) There are some NGO's that are not very particularly interested in safe abortion. They may be interested in the subject of post-abortion care services as part of the emergency obstetrical and neo natal care package. But not going towards safe abortion care (Interview-ACMS).*

3.4.8 Opportunities for strengthening safe abortion network

For the promotion of safe abortions, grassroots civil society organizations are doing everything possible to alert young people in particular to the risks of clandestine abortions. Their strategy is essentially based on permanent awareness, through the media, posters, and celebrations of the youth party, school, and community festivals and roundtables discussions. In this strategy, the network of peer educators plays a fundamental role.

And as one of the NGO members states:

> *"We organize workshops, we also advocate through our various contacts, whenever we have the opportunity to have a decision maker with us in a meeting or in an interview, we try to send a message in this direction- Here we have brochures that we have produced to try to talk about these effects and its consequences that we also distribute to these different leaders each time we invite them to a workshop or when we go to them... "*

However, this advocacy-based strategy is considered insufficient by a MoH official.

> *"I do not feel that it's done enough in our country, I think we did not describe the harmful effects of unsafe abortions, people do not always know very well ... I think that if we sensitizes with even the anecdotal facts to say how the abortions could spoil the life to the people, that can touch the public opinion and the people will say to themselves, it is necessary to pay attention to the plea on the safe abortion ... Then me the first thing is to inform ".*

For a member of ARGOC,

> *"It is possible to put in place a policy that makes it so that the management of abortions and its complications is free, it is possible. ……we have been able to vaccinate our children for free, we can also achieve abortion services if we consider that it is a cause of death, but also at the level of community you have to advocate there because that's where the girls come out”*

3.4.9 Current role of professional society in safe abortion advocacy

From the presentation of prof Leke during the workshop, the key informant interviews and the workshop discussions it emerged that currently, advocacy is being done around the issue of liberalizing abortions. These advocacy efforts are at various levels and strategies. At the level of professional associations, scientific meetings are organized during which pleas are formulated. This is the example of SOGOC that our informant emphasizes

> *"Well, we already have our scientific meetings that are attended by a lot of people, [...] the Franco-Cameroonian congresses, which also attracts a lot of people. [...] Some research has also been done to draw the MOH's attention to the context of maternal mortality. We did some small investigations that revealed adverse effects, that …. could attract people and Ministry of Health attention on these things. "(SOGOC informant)*

At the level of parliament and at the level of the government, advocacy is being made to present the risks of maternal mortality that women face and the opportunities that could be offered by breaking down barriers to abortion.

3.5 Stakeholder Workshop

Throughout the sessions of the workshop, four overarching themes were agreed upon in line with the suggestions made by the facilitator based on the Kenya themes: improve legal dimensions; transforming social norms at all levels; improve inclusivity; ensure a process of generation and use of evidence for action. The bullet points under each theme below are examples of needs that came up throughout and could be integrated into the action plan. For an overview of the themes and bullet points informing the action plan see annex 4

Discussions on terminology addressed both the use of 'pro-life' for abortion opponents and the use of 'safe abortion'. It was agreed that the term of pro-life should not be used as all sides on the debate spectrum are in favour of life. The discussion on the use of advocacy for 'safe abortion' showed the concern that this would produce resistance whilst advocacy for comprehensive abortion care (CAC) including safe abortion opens more opportunities for dialogue.

3.5.1 Social Networks

During group work social networks for safe abortion were identified. Annex 5 provides a summary of allies and networks where potential allies could be found. This should be seen as a dynamic table. Along the way new allies can be identified and potential allies can move.

3.5.2 Strengths, Weaknesses, Opportunities and Threats

The main outcomes of the SWOT analysis can be found in Annex 6.

3.5.3 Action plan

As a final exercise, groups started on defining objectives and activities for an action plan on safe abortion advocacy. The action plan has the overall objective to improve the capacity of SOGOC on abortion advocacy to then, ultimately, increase the access to safe abortion and reduce morbidity and mortality as a result of unsafe abortion. Activities should serve to reach the objectives and will include the different advocacy levels and social networks addressed during the workshop.

After the stakeholder workshop the consultancy team continued to develop the action plan, including deliverables. The action plan will continue to be developed in consultation with SOGOC and FIGO.

A preliminary action plan can be found in Annex 6.

4 Conclusion and lessons learnt

The secondary and primary data collected and analysed in this report provide ample evidence that the magnitude of induced abortion is far from marginal and has a significant effect on the maternal mortality rate in Cameroon. As a public health challenge in Cameroon, this phenomenon affects, especially, adolescent girls and women between 20 and 29 years from various social and cultural backgrounds.

SOGOC is well placed to play an important role in safe abortion advocacy or comprehensive Abortion Care. The terminology to be used requires further discussion. However, expanding activities of the organisation will require better administrative, financial and managerial support.

Various NGOs such as PSI, IPPF, Marie Stopes, local NGOs and the associations of nurse midwives and gynaecologists and obstetricians are committed to address the sexual and reproductive health rights SRHR and needs of women, and reduce the demand for unsafe abortion by improving access to safe abortion. A social network for improving SRHR exists and is to some extend formalised. Nurse midwives and resident gynaecologists and obstetricians are members of SOGOC. SOGOC is asked to provide advice and training on technical issues related to safe abortion and post abortion care to various NGOs and health providers and the MOH. However, abortion advocacy is still minimal and the social network and the role of SOGOC can be strengthened to change public opinion on safe abortion.

Post-abortion care in hospitals is still limited due to financial constraints, insufficient health care staff and missing MVA equipment. The analysis of the data collected indicates a good awareness of the multifaceted dangers associated with abortion and indicates a need to strengthen capacity of service providers to provide safe abortion and strengthen the referral network. National guidelines and quality assurance are important gaps to be addressed.

Socio-economic factors including gender, cultural religious and social norms, values and practices influence unsafe abortions. The reasons given by women to justify the use of abortion are varied, but financial constraints, births too close together or too many, the need to continue studies, being unmarried and contraceptive failure are the most important. In addition, the prevention of unintended pregnancy is complicated by a lack of access and use of contraceptives in married as well as unmarried women and girls. Sexuality education and access to youth friendly services for adolescents is still very limited in Cameroon. Reasons for unsafe abortion include fear of stigma, legal barriers and costs. Transformation of social, cultural and gender norms values and practices influencing perception of and access to safe abortion and contraceptives are important aspects of advocacy for safe abortion

Legal constraints, limiting legal abortion to when a pregnancy gravely endangers the woman's health, in case of rape and severe foetal malformations, form an important barrier to access to safe abortion. In addition the complicated requirements for three signatures of physicians and court involvement in the case of rape complicates and delays access to safe abortions, especially in rural areas. The attitude towards a more liberalised law on safe abortion requires a shift in public opinion especially among political leaders and parliamentarians. A concentrated well developed lobby across the social network and including UN organisations to influence government will be required to shift the law. The opinion of the various people we met, including the obstetricians and gynaecologists of SOGOC, remains quite diverse on what to aim for in improving access to safe abortion. Consensus

needs to be reached within the social network about the aim for a more liberalised law that meets the need of women.

Cameroon shows considerable gaps in data available on safe abortion. There is no national data available on safe abortion or post abortion care. Data available is limited to results of incidental cross sectional studies conducted in referral hospitals. Data on perceptions of and experiences with safe abortion in the community is very limited and needs updating to inform lobby and advocacy activities.

4.1.1 Recommendations for future program

Building its base as a safe abortion advocate, the association will require addressing the various and potential challenges as were identified during the key informant interviews and the two-day's workshop. This could include the following:

- Strengthening the management and organization of SOGOC as a formidable agency for safe abortion advocacy.
- Establishing a coordinated and vibrant network of associations that are supportive of safe abortion.
- Contributing to greater acceptance of safe abortion within the context of the Cameroon law.
- Improving the legal framework to better meet the needs of women.
- Ensuring a process for data generation and use for monitoring and planning for services.

These recommendations, identified in collaboration with SOGOC, are taken forward and translated into a preliminary action plan with tangible activities and outcomes. The action plan will be further developed in collaboration with SOGOC and FIGO and be a source of inspiration for the development of a future program proposal for safe abortion advocacy in 10 countries (Kenya, Benin, Cameroon, Ivory Coast, Mali, Mozambique, Panama, Peru, Uganda, Zambia).

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6 Annex 1 Program and participants of stakeholder workshop

Due to time constraints the program was adapted during the days. Starting time was later and some workshop components were skipped. (Marked in italics)

Time	Content	Facilitator
Day 1 26 Feb		
8.30– 9.10	Introduction: Welcome and prayers President society Getting to know each other, expectations, purpose, objectives, agenda, facilitator's participant roles, group norms, evaluation process, housekeeping	Prof Leke
9.10-10.20	Presentation preliminary country results; validation of analysis; dialogue about reasons for abortion and what needs to improve to meet women's need for safe and legal abortion	Prof Leke, Prof Antoine Socpa
10.20-10.35	Break	
10.35 -11.00	Presentation and discussion results of group work dialogues	
11.00-11.30	Implications of national abortion laws on access to safe abortion.	
11.30-12.30	Share positions and personal beliefs and discuss professional responsibilities	
12.30-13.30	Lunch	
13.30-14.00	What is advocacy: concept, levels and challenges	
14.00 -14.30	*Advocacy perspective, risks and benefits in advocacy (shortened)*	
14.30-15.00	Roles in advocacy	
15.00-15.15	Break	
15.15 -16.00	Roles in advocacy continued	
16.00-16.25	*Power dimensions in advocacy*	
16.25-17.15	Advocate for safe abortion care	
17.15 –17.30	Evaluation of the day	
Day 2: 27 Feb		
8.30-9.00	Welcome and prayers Recap of day 1 by 2 volunteer participants identified day before	Two volunteers
9.00-10.00	Social networks and reaching different audiences	
10.00-10.30	Break	
10.30-11.00	Address parked issues (none parked)	
11.00-12.30	Presentation of achievements weaknesses barriers and opportunities of abortion project. Then: strengths, weaknesses, opportunities and threats of the national association for abortion advocacy.	Prof Leke
12.30-13.00	Lunch	
13.00-15.00	Develop an action plan for abortion advocacy in small groups	Dr. Filbert Eko
15.00-15.15	Break	
15.15 -16.00	Continue develop action plan	
16.30-17.00	Presentation and discussion action plans in plenary	
17.00-17.30	Evaluation and goodbye	

6.1 Elaboration on Content of the workshop

The workshop contained eight components:

1. **Introduction:** a session where the background and objectives of the needs assessment and the stakeholder workshop were explained, logistics of the facilitations process, roles and group norms were discussed. Professor Robert Leke, president of the society, opened the day and gave a presentation on SOGOC journey on abortion.
2. **Presentation of draft country results and identification of women's needs for safe and legal abortion:** Professor Leke addressed the country background, legal and political context, abortion stigma and service delivery environment. Professor Antoine Socpa presented existing advocacy on abortion and SRHR in Cameroon. In a second part of the session case studies about women having obtained unsafe abortion were discussed and analysed in groups. Needs from the perspective of the woman were identified with respect to availability, access to and quality of safe abortion services, environmental and legal dimensions.
3. **Share positions and personal beliefs; discuss professional responsibilities:** a session where personal barriers and motivations to provide safe abortion were explored, with the emphasis that everybody has a right to personal beliefs, which are not questioned. Personal beliefs were benchmarked against professional responsibilities and FIGO's resolution on conscientious objection was discussed in the light of remaining barriers (such as limited professionals available in the country).
4. **What is advocacy and why providers as advocates**: a session to define advocacy and emphasize health providers' unique strength for advocacy, based on: first-hand experience, trustworthiness, extensive network, intermediary client-provider, prestige and status.
5. **Three roles of an advocate:** a session to explore one's advocacy role as an educator, witness or persuader within different advocacy scenarios: provider-client, provider-provider, provider-professional network, provider-media, provider-policymaker.
6. **Social networks and reaching different audiences:** a session to explore social networks for advocacy on safe abortion, identify current and potential allies and ways to reach them.
7. **Strengths, weaknesses, opportunities and threats (SWOT) analysis:** to the abortion advocacy capacity of SOGOC.
8. **Development of an action plan:** a session to, based on the outcomes of the previous session components, identify objectives and activities for the next proposal on safe abortion advocacy.

Participants of the workshop KIT/FIGO/SOGOC PROJECT, WORKSHOP ON SAFE ABORTION HOTEI. MANSEL: 26 TO 27 FEBUARY 2018

N°	Profession	Name
1.	President (SOGOC)	Pr Robert I. 1. LEKE
2.′	1er Vice-President (SOGOC)	Pr Nelson FONIULU
3.	2éme Vice-President (Douale) (SOGOC)	Dr Jacques TSINGAING KAMGAING
4.	General Secretary (2hours attendance) (SOGOC)	Dr Rebecca TONYE
5.	*Treasurer* (SOGOC)	Pr Philip NANA N1OTANG
6.	*Focal Point* (SOGOC)	Dr Eko Eko Filbert
7.	Obs/Gyn (SOGOC)	Dr Ngo Dingom Madye
8.	Obs/Gyn (SOGOC)	PrNkwabong Elie
9.	Obs/Gyn (SOGOC)	Dr ESSIBEN Felix
10.	Resident (SOGOC)	Dr Achuo A.FI.
11.	Resident (SOGOC)	Dr Ojonq Samuel
12.	Nursing Officer, on behalf of the ministry of Family Health	Mme Njitchouang Martine
13.	IS/SF NOLFOWOP (No Limit for Women project)	Mme Etame Odette
14.	Consultant and president ASFAC (Midwifery association Cameroon).	Mme Atachamie Annie
15	PSI/ACMS	Mme Nsobirka Juliet Fai
16	Project coordinator Cameroon Association of Family Welfare	Mr. Edjenguele Lotti
17	Care Cameroon	Mme Halima Mohamadou
18	OFSAD (Organisation for Health, Food Security and Development?	Mme Kenfack nee Tolevi
19.	RENATA (National Association of Aunties in **Cameroon)**	Mme Aba Fouda C.
20.	IS/SF ASFAC	Mme Ewolo Esther
21	UCAC (Universite Catholique de L'Afrique Centrale)	Mlle Makuate Tamed

Two secretaries and the driver assisted during the workshop and 2 facilitators also took part in the workshop

7 Annex 2 *Women's perceptions and experiences of unsafe abortion*

From the interviews various respondents commented on women's perceptions and experiences with unsafe abortions. Beyond the legal and political obstacles respondents reported a lack of financial means as a barrier for safe abortions. Another obstacle reported is the fear of exposure to rejection in communities.

> *"There are sociocultural barriers, and abortion is not always welcome, whether it's with the teenage girl who is not supposed to get pregnant, whether it's with the married woman who is not is not able to tell her husband that she does not want this pregnancy. There are also so-called religious barriers, because the position of the Christian church whether of Islam, the two main religions in Cameroon, are quite clear, they are anti-abortion squarely and we have a population that listens very much to their religious leaders [...] " (ARGOC member)*

An experience witnessed by a SOGOC member tells the following story:

> *"(….). a 13 year old girl was send by the MOH because she was raped by a would be priest. She became pregnant and was already beyond 12 weeks pregnant. We reached out to the MOH but nothing could be done. We had to let her carry the baby to term and do a caesarean section. The girl was traumatised and had psychological problems and suffered from stigma in the community.*

The newspapers are another source of information about perceptions of induced abortion in the community:

Case 1: Abortion with bleach in Cameroon

This is the story of a young Cameroonian who narrowly escaped death. It all starts when she learns that she is pregnant. Panicked, she decides to make a decision for the less radical. "*She did not find anything better than bleach. Once the liter of disinfectant was swallowed, the apprentice abortion fainted in the yard of the family concession, suffering from violent abdominal pain. "" The girl could not do ten meters. She falls and begins to choke. …..the cries of the parents attract the neighborhood* "(Cameroon Tribune, 6/11/2012).

Case 2: A 30-year-old woman decided to terminate her pregnancy without her husband's knowledge because she was pregnant with another man.

"*I am as surprised as everyone else. I would never have imagined that she led a double life without my knowledge. These words are those of a husband at once bruised by the disappearance of his wife, and surprised by the news that he has just learned to know that his deceased wife was cheating on him. Everything happens last week at the Ekounou district in Yaoundé. Hasta, a 30-year-old woman married to Samuel, performs a Voluntary Pregnancy Interruption (IVG) that she carried in her womb without her husband's knowledge. What she did not expect was she was going to leave her life there. Indeed, following complications that occurred after the abortion, the young woman died in her home. "I went out early in the morning to work. I knew she just had a stomach ache and she was not even bothering too much pain. I knew it was fleeting. At 1.00 pm, the neighbor informs me by phone that my wife is dead. I immediately went home, I found my wife stiff dead, "says the husband still in shock. According to Ines, a neighbor of the couple, Hasta confessed to her before her death that she had contracted a pregnancy that was not her husband's. She would have been from a man who had*

been introduced to her by her parents who did not approve of her union with Samuel because she was from the Littoral, unlike Hasta and her lover, both from the North. By wanting to interrupt her pregnancy of three months of age, the deceased hoped to save her home and find her daily routine. She leaves behind two children and a weeping husband (ENB August 17, 2017)

8 Annex 3: Overview of outcome online survey

The responses to the online survey comes in an additional file, in PowerPoint format.

9 Annex 4 Workshop outcomes for action plan

1. **Improve legal dimensions**
   - Identify legal partners for improving the legal dimension for safe abortion
   - Obtain copies of legal documents on current law on abortion in Cameroon
   - Compare existing Cameroon law on abortion to those of other countries practising safe abortion (identifying legal loop holes).
   - Sum up the stakeholders to (SOGOC; MoH; NGO, etc.) to draw up a proposition of Cameroon safe abortion law.
   - Send the draft of law through MoH to the National assembly for adoption
   - Elements of verification:
     - Resolution of meetings
     - Validation and publication of the new abortion law (Decret d'application)
   - Follow up discussions clarified that physical conditions, failed contraception and mental health and social conditions should be added in the law.

2. **Transforming social norms at all levels:** national policy level, county policy level, professional network, facility level, community level etc.
   - Reinforce sex education at the level of the family
     - Capacitating parents on responsible parenthood and provision of sex education and education of youths on modern methods of family planning.
     - The outcome was that all children benefit from sex education at home measurable by the number of children making informed consent on reproductive health decisions and the contraceptive procurement rate among youths.
   - Promote community awareness on safe abortion, activities include;
     - Identify champions among religious and traditional leaders to influence peers e.g Imams, queen mothers etc. and
     - Community communication on safe abortion via dialogue, mass communication etc- creating awareness amongst the police force
     - Provide behaviour change communication.
     - The outcome of objective two was to be evaluated by the number of safe abortion champions advocating for safe abortion, change of attitude towards clients.
   - To promote sex-education in schools. The activities proposed here were
     - Provide sex education to students and teachers and
     - Capacitate peer educators in school.
     - The outcome here would be measured by the number of students taking decisions on RH and decreasing number of unintended pregnancies in schools.
   - Improve the environment for provision of safe abortion in services.
   - Following discussions, it was suggested that the place of these activities be clearly made in reduction of maternal mortality. Also, it was suggested that provision of family planning methods to school children who are already sexually active be included as an activity

3. **Improve inclusivity**: networking, partnerships, comprehensiveness and holistic coverage of issues and needs
   - Work with actors of reproductive health such as ACMS, CAMNAFAW, ALVE, OFSAD etc. on improving safe and legal abortion
   - Work with actors involved in promotion of women´s right e.g. RENATA, ACAFEM etc. on improving safe and legal abortion. Activities could include:

- Signing of MoU
- Communication strategy
- Putting in place of a platform for communication for increase sensitization and
- Monitoring and follow up of activities.

4. Ensure a process of generation and use of evidence for action

- Collection of available data
- Operational research in the community and hospitals
- Use of DHS to collect data in the community
- Presentation of results and data to stakeholders and community mobilization on use of data for implementing change

10 Annex 5 Social Networks

Level	Allies and potential allies	Means to reach alleys and potential allies
International level	• FIGO •	• Advocacy documents. • Workshops on advocacy. • Discussion groups • Training • Develop a memorandum of understanding with Ministries and NGOs) • Organise meeting and public information events on the consequences of unsafe abortion • Organisation of educational events and ceremonies • Popular theatre; facebook, whatsapp • Organise conferences and public debate on abortion Broadcast TV films on abortion. • Outdoor events, sports, music to discuss health including prevention of and safe abortion and provide free HIV, hepatitis screening (reaching young men) • Stakeholders working for the promotion of women rights can be sensitized towards improving safe abortion • Distribution of flyers Letters • Invite potential allies/opponents to meet with champions of abortion ('victims') to listen to their stories.
Professional network	• SOGOC • ASFAC • SOCAPED • Directors of hospitals • Network of parliamentarians women, first lady • ACAFEJ (Cameroon Association of Jurists Women), • ACAFEM (Cameroon Association of Mayors Women) • RENATA (National Network of Tantines), • ONMJ	
National and policy level	• MOH • Ministry of women's Affairs; social welfare • OMS (WHO) • UNFPA • Sports/music celebrities (to use their image for prevention of and safe abortion advocacy) • Syndicate	
County policy level	Not distinguished	
NGO's, bi- & multilaterals and networks	• ACMS (PSI) • CARE • CAMNAFAW (Cameroon IPPF) • OFSAD • FESADE • ALVF • NOLPOWOP • GIZ	
Legal network	• Law makers, state ministries, parliament,	
Religious network	• Religious groups (often opponents but need to look for potential allies)	
Community	• Traditional rules FUN ASSOCIATION • Community based organisations • Youth Associations/clubs •	
Media	• Association of journalists	